93-755

No. _____

In The

Supreme Court of the United States

October Term, 1993

MARY KUHL, BUDDY KUHL, JR., MARNIE K. KUHL,

Petitioners,

v.

LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR A WRIT OF CERTIORARI

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I. QUESTIONS PRESENTED

1. Whether the preemption doctrine of the Employee Retirement Income Security Act of 1974 (ERISA), at 29 U.S.C. § 1144(a), and this Court's decisions interpreting that provision, compel the preemption of state law claims which arise when an HMO undertakes the medical care of a patient/member (which includes the cancellation of a scheduled medical procedure), dictates the timing and location at which medical care is to be rendered, and disregards the medical advice and recommendations of the patient/member's treating physicians and specialists?

2. Whether the courts below, in considering the defendant's Motion for Summary Judgment, failed to employ the standards and presumptions dictated in previous decisions of this Court when they improperly rejected the evidence averred by the non-moving party and drew inferences in the light most favorable to the movant?

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JURISDICTION

On December 26, 1991, the Honorable D. Brook Bartlett in the United States District Court for the Western District of Missouri granted defendant's motion for summary judgment and denied plaintiffs' motion to remand, holding that plaintiffs' state law claims were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq*. A copy of that decision, unreported, is set forth in Appendix C. On reconsideration, Judge Bartlett affirmed his previous order granting defendant summary judgment and denying plaintiffs' motion to remand. The June 15, 1992 affirmance, also denying plaintiffs' motions to alter or amend the judgment and for leave to amend their complaint, is set forth in Appendix D. On June 15, 1992, judge Bartlett also granted defendant's motion to dismiss plaintiffs' second complaint in which plaintiffs sought to alternatively plead causes of action recognized under ERISA for which "other equitable relief" could be recovered. A copy of the District Court's June 15, 1992 dismissal of plaintiffs' second complaint is set forth in Appendix E.

A consolidated appeal was taken by plaintiffs and, on July 7, 1993, a panel of the United States Court of Appeals for the Eighth Circuit issued its decision, affirming the decisions of the District Court. A copy of the panels' opinion, which is reported at 999 F.2d 298, is set forth in Appendix A. The plaintiffs' timely request for rehearing by the Eighth Circuit was denied on August 13, 1993. A copy of the denial of plaintiffs' request for rehearing is set forth in Appendix B. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case turns on the applicability of the preemptive effect of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C § 1001, *et seq.*, particularly § 514(a) of ERISA, 29 U.S.C. § 1144(a), set out in the Statutory Appendix.

STATEMENT OF THE CASE

These consolidated cases involve whether Lincoln National Health Plan of Kansas City may take deliberate steps, without threat of legal recourse, to undertake the care provided to a member/patient by utilizing its medical decision-making to dictate the care he will receive, rather than providing a simple negative response in answer to a claim for benefits. The cases present the question of whether the HMO may seek the protection of ERISA, after its negligent medical decisions and actions have resulted in death, on the premise that the HMO was simply "administering benefits." The issues presented herein are fact-sensitive and better illustrated with an understanding of the facts, from which these questions arise, as set out below:

On April 29, 1989, Buddy Kuhl, Sr. suffered a heart attack and, with the approval of his designated primary care physician, was placed in the care of Dr. Bernard Levi, a heart specialist at Menorah Medical Center in Kansas City, Missouri. After several weeks of careful examination, tests and care of Buddy Kuhl, Dr. Levi indicated that heart surgery would be necessary, including open-heart LV aneurysmectomy and coronary by-pass surgery. This

recommendation was confirmed by Dr. Ahuja in a second opinion. In a letter setting out that second opinion, dated May 23, 1989, Dr. Ahuja stated that Buddy Kuhl was a "candidate for sudden death" and needed the recommended surgery "in the next few weeks."

Between the dates of June 13, 1989 and June 16, 1989, Buddy Kuhl underwent extensive tests at Menorah to determine the extent of the heart damage and to confirm the proper course of treatment. Dr. Levi instructed Buddy Kuhl that the best course of action was to have the bypass surgery and an aneurysm removal. The surgery was originally scheduled with Dr. Hannah of Kansas City, a heart surgeon at Menorah Medical Center in Kansas City, Missouri. However, after closer review of the test results and consultation with a team of Menorah Medical Center physicians specializing in cardiology, and after consultation with physicians at Barnes Hospital in St. Louis, Dr. Levi determined on June 20, 1989 that, because of Buddy Kuhl's condition known as inducible ventricular tachycardia and his need for computerized mapping, Buddy Kuhl's best chance of survival could be maintained if the surgery were to take place at Barnes Hospital in St. Louis, Missouri. Kansas City area hospitals did not have the equipment to perform the technically-advanced computerized procedure that Buddy needed and the surgeons at Barnes were far more experienced and successful than their counterparts in Kansas City. Therefore, Dr. Cox, a world-renowned heart surgeon, specializing in computerized cardiac mapping and bypass surgery on patients with ventricular tachycardia, was scheduled to perform the surgery with Dr. Cain's consultation.

After discussion with Dr. Cain's staff, Buddy Kuhl selected a July 6, 1989 surgery date at Barnes Hospital, with an admission date set for July 2, 1989. Dr. Hannah, the Kansas City cardiac surgeon originally scheduled to perform the surgery, and a participating provider under the Lincoln National HMO, agreed with Dr. Levi's determination that Buddy Kuhl's best interests would be served by having the surgery at Barnes. He told Buddy Kuhl so on June 21, 1989, and on June 22, 1989 he sent a letter to Dr. Levi to the same effect. Mary Kuhl informed Lincoln National of Dr. Hannah's opinion as well.

Dianne Long, a utilization review coordinator (R.N.) for Lincoln National Health Plan of K.C., received a phone call from Barnes Hospital on June 20, 1989. At that time, Dianne Long learned that the surgery had been scheduled at Barnes. Thereafter, without consultation with Dr. Levi, without consultation with Dr. Cain or Dr. Cox, and without any kind of consultation whatsoever with Buddy Kuhl, Lincoln National made a decision on June 23, 1989 to cancel Buddy Kuhl's surgery at Barnes Hospital.

Lincoln National then took steps to schedule an appointment for Buddy Kuhl to see Dr. Brodine at Research Medical Center in Kansas City regarding the performance of the surgery in Kansas City, rather than in St. Louis, as recommended to be in the best interest of Buddy Kuhl by his physician, Dr. Levi. In fact, the consultation with Dr. Brodine was ultimately scheduled by Dianne Long on June 27, 1989. That appointment (still unbeknownst to Drs. Cox, Cain, Levi or even Buddy Kuhl) was scheduled for the same date as Buddy's surgery in St. Louis (July 6, 1989). The appointment with Dr.

Brodine (mutually exclusive of surgery on the same day) was initiated and scheduled by Lincoln National in direct contravention of the advice and recommendation of Dr. Levi, the cardiac specialist assigned to Buddy Kuhl's care. In fact, when Dianne Long told Dr. Levi (on or about June 23, 1989), that the HMO was considering the possibility of surgery at Research Medical Center, Dr. Levi told her that he wanted Buddy Kuhl's surgery to take place at Barnes Hospital and that the surgeons at Research were "incompetent and inadequate."

Dr. Levi then spoke with Dr. Agee, the Medical Director for the Lincoln National HMO, and told him of the recommendation to have the surgery performed at Barnes and the reasons for that recommendation. Then, on June 23, 1989, Dr. Levi wrote to Lincoln National, in care of Dr. Agee. Dr. Levi advised Lincoln National that Buddy Kuhl needed a special heart surgery which could only be performed by Dr. Cox in St. Louis. Dr. Levi explained that if the surgery was performed by Dr. Cox in St. Louis, Buddy would have an 80-85% chance at survival; if the operation was performed in Kansas City, Buddy's chances of survival were "dismal".

Nevertheless, Lincoln National telephoned Barnes Hospital and canceled Buddy Kuhl's surgery. According to the sworn testimony of Dr. Levi, in cancelling the surgery at Barnes and scheduling an appointment for Buddy Kuhl to see Dr. Brodine instead (all directly contrary to the advice and recommendation of Dr. Levi) Lincoln National literally assumed the care of Buddy Kuhl.

After assuming the role of decision-maker with respect to the care to be provided to Buddy Kuhl, Lincoln National contacted Buddy Kuhl on June 27, 1989. According to his own notes, recorded by Buddy Kuhl in his personal calendar on or about June 27, 1989, "The Ins. Co. called and canceled my Oper. in St. Louis[.] Set up appt. w/Dr. Brodine in K.C. to see about oper."[1]

Dr. Brodine later concurred with Dr. Levi's recommendation (as had Dr. Hannah) that the heart surgery should be performed by Dr. Cox in St. Louis, due to the use of technically-advanced computerized cardiac mapping facilities at that hospital. He spoke with Dianne Long at Lincoln National and conveyed these results to her on July 6, 1989. Nevertheless, Lincoln National waited until July 20, 1989 to call Buddy Kuhl to inform him that the HMO would authorize surgery at Barnes.

Dr. Levi was informed, by copy of a letter written on July 20, 1989, that the HMO was following Dr. Brodine's recommendations and would authorize surgery in St.

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[1] On July 18, 1989, Buddy Kuhl prepared a letter to his designated primary care physician, Virginia Grimes, setting out his concerns that "the Insurance Company is playing with my life." That letter also tells of how Buddy Kuhl learned that his surgery had been cancelled by the Lincoln National HMO without his advice or consent. The letter reads, in that regard:

> Lincoln National determined that the operation could be performed in Kansas City at Research Hospital. The insurance company arranged an appointment with Dr. Brodine at Research Hospital on July 6th. I was informed of the appointment by the insurance company at which time I was also told that insurance company cancelled my appointment in St. Louis as initially arranged by Dr. Levi.

Louis. That letter also directed Buddy Kuhl that, after surgery, "all hospital care must be rendered by Dr. Levi." Thus, after assuming the care of Buddy Kuhl on June 23, 1989, Dr. Levi has testified that Lincoln National returned Buddy Kuhl to his care on July 20, 1989.

In the HMO's July 20, 1989 letter to Buddy Kuhl, an HMO representative stated that the Health Plan would "authorize [the] surgery" at Barnes Hospital. Buddy Kuhl immediately contacted Barnes Hospital to reschedule the surgery that had been previously canceled by the HMO. Unfortunately, Buddy was informed that the surgery could not be performed until September, 1989 due to the unavailability of the surgical team.

Buddy and Mary Kuhl traveled to St. Louis on September 2, 1989 in anticipation of surgery. However, after tests were conducted at Barnes Hospital in September, 1989, prior to the scheduled surgery, Dr. Cox found that Buddy Kuhl's heart function had deteriorated to such an extent that "I no longer felt he was a reasonable operative candidate. By that I mean, I did not believe [I] could get him through the heart operation alive." As a result, "we recommended to him that he be evaluated for cardiac transplantation because that is really the only thing left to offer." The physicians at Barnes asked that additional testing be done and that Buddy Kuhl be put on a heart transplant waiting list at Barnes Hospital. Lincoln National again refused. Buddy was then put on a heart transplant waiting list at Kansas University Medical Center. Buddy Kuhl died on December 28, 1989 waiting for that heart transplant. The medical explanation for Buddy's death was ventricular tachycardia, the specific

condition for which Buddy Kuhl was originally to receive technologically-advanced treatment at Barnes Hospital.

Thereafter, plaintiffs filed their suit in state court, alleging only state court causes of action. Plaintiffs sought to recover for the tortious conduct of the defendant HMO, by virtue of the acts and omissions of its agents. Specifically, plaintiffs asserted claims for medical malpractice, tortious interference with a contract, and the intentional infliction of emotional distress upon Mary Kuhl. Plaintiffs alleged that the HMO had canceled Buddy Kuhl's life-saving surgery, without the knowledge or consent of Buddy Kuhl and without the knowledge (and against the express advice) of his treating physician, Dr. Levi, and had undertaken to dictate the course, timing and location of Kuhl's medical care. Defendant, rather than addressing the allegations asserted, sought to shield itself from liability under the ERISA preemption umbrella, removed the case and sought summary judgment.

The District Court granted the defendant's Motion for Summary Judgment and denied plaintiffs' Motion for Remand, stating that the plaintiffs' state law claims arose from the "administration of the Plan" and were therefore preempted by ERISA.[2] The Eighth Circuit Panel affirmed the decision of the district court, seemingly for two reasons: First, the Panel believed that Lincoln National's

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[2] Plaintiffs later filed a motion to alter or amend the judgment, and also filed a second complaint in which they sought to alternatively plead causes of action recognized under ERISA. Plaintiffs' motion to alter or amend was denied, and the District Court dismissed plaintiffs' second complaint.

cancellation of Buddy Kuhl's previously-scheduled surgery, and other acts, did not go beyond the administration of benefits and did not amount to the undertaking of medical decision-making for Buddy Kuhl. Second, the Panel agreed with the district court's decision that the plaintiffs' claims were based on the contention that Lincoln National improperly processed Buddy Kuhl's claim for medical benefits. The Panel found, therefore, that Lincoln National's actions at issue related directly to its administration of benefits, and the lower court's decision, in which the plaintiffs' state law claims were deemed to be preempted by ERISA, was affirmed.

VII. REASONS FOR GRANTING THE PETITION

A. The Eighth Circuit and the District Court Erroneously Determined that an HMO's Decision to Cancel a Patient/Member's Life-Saving Surgery, and Other Acts, were "Related to" the Administration of Benefits

The Eighth Circuit and District Court decisions are inconsistent with this Court's holding that ERISA preemption is not an absolute or universal grant of federal jurisdiction. In fact, this Court has recently decided that ERISA plans may be sued in civil actions and that some state law claims, including tort claims, are not afforded the protection of the complete preemption doctrine established under ERISA. "These cases – lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, *or even torts committed by an ERISA plan* – are relatively common place." *Mackey v. Lanier Collections Agency*, 486 U.S. 825, 108 S. Ct. 2182, 100 L.Ed.2d 836, 846 (1988) (emphasis added); *See*

also, Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236, 248-49 (5th Cir. 1990); *Abofreka v. Alston Tobacco Co.*, 341 S.E.2d 622 (S.C. 1986).[3]

Despite its broad construction of § 514(a), this Court has also indicated that it will not extend the "relate to" language to its outer limits. *New Orleans Sheet Metal Worker's Local 11 Health & Welfare Fund v. ABC Ins. Co.*, 1990 W.L. 103118, 18 E.B.C. 1655 (E.D. La. 1990). State

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[3] Many cases have found tort claims to be outside of ERISA's preemption umbrella. *See, Clark v. Coats & Clark, Inc.*, 865 F.2d 1237, 1243-44 (11th Cir. 1989) (tort claims which had no effect on plan administration were not preempted); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 825 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988) (spouse's claim for emotional distress in connection with harm arising from a benefits denial is not preempted); *Ethridge v. Hader House Restaurant*, 861 F.2d 1389, 1404-05 (9th Cir. 1988) (ERISA did not preempt a claim for tortious discharge, based upon a reference to loss of employment and benefits); *Framingham Union Hosp., Inc. v. Travelers Inc. Co.*, 721 F. Supp. 1478, 1490 (D. Mass. 1989) (involving a claim for accountant malpractice, claims for unfair and deceptive practices which induced purchase, renewal and conversion of insurance policies, and negligent supervision of an agent against the plan insurer, were not preempted); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) (hospital was allowed to proceed against an ERISA insurance company and its agent for negligent misrepresentations of coverage). *See also, Nat'l Expert Care Consultants, Inc. v. United Airlines, Inc.*, 1991 W.L. 24387, 59 U.S.L.W. 2588 (S.D.N.Y. 1991); *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984); *Fort Halafax Packing Co. v. Coyne*, 482 U.S. 1, 7 (1987); *Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752 (10th Cir. 1991); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 556 (6th Cir. 1987); *Vilas v. Lyons*, 702 F. Supp. 555, 563 (D.N.D. 1988); *Pizlo v. Bethlehem Steel Corp.*, 884 F.2d 116 (4th Cir. 1989); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir. 1989).

actions which affect plans in too tenuous, remote, or peripheral a manner will not be preempted as a law relating to the plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100, 103 S. Ct. 2890, 2901, 77 L.Ed.2d 490 (1983); *Uselton v. Commercial Lovelace Motor Freight, Inc.*, 940 F.2d 564, 583 (10th Cir. 1990). "ERISA does not preempt claims that are only tangentially involved with a benefit plan." *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991). ERISA preemption provisions surely do not extend to every state law claim that, however remotely, actually involves an employee benefit plan. *Giardiello v. Balboa Ins. Co.*, 837 F.2d 1566, 1571 (11th Cir. 1988). When a state law "does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the law has some economic impact on the plan does not require that the law be invalidated." *Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752, 754 (10th Cir. 1991); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir.), *cert. denied*, 472 U.S. 1008, 105 S. Ct. 2702, 86 L.Ed.2d 718 (1985).

The Eighth Circuit and District Court erroneously disregarded the limitations set by this Court and others on the scope of ERISA's preemptive effect. In the courts below, the plaintiffs demonstrated that the HMO had *undertaken* the care of Buddy Kuhl, and through its representatives, dictated the services to be provided to him, along with the location and timing of those medical procedures. These decisions, on which the plaintiffs' state law claims were based, far exceeded the mere administration of benefits and, while tangentially associated with the employee benefit plan, should not have been deemed

by the courts below to be related to the administration of benefits.

The decision-making at issue herein is a direct result of the fact that HMOs have become immersed in the medical decision-making process. This Court recently denied a petition for a Writ of Certiorari in which the Fifth Circuit highlighted this phenomenon. In fact, in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), *cert. denied*, ___ U.S. ___, 113 S. Ct. 812, 121 L.Ed.2d 684 (1992), the Fifth Circuit recognized that an HMO is engaged in rendering medical recommendations and making medical decisions. While the *Corcoran* court found that those medical decisions were just "part and parcel" of benefit determinations, the Fifth Circuit also assumed that the HMO's decision-making would affect only the *payment of benefits* for medical services rendered or to be rendered. This aspect of the Fifth Circuit decision, while harsh, is arguably consistent with the law. That is, in *Corcoran*, the patient/member was simply told that the HMO would not pay for the medical procedures her physician had recommended. She then had the option of paying for those services herself and haggling with the HMO for reimbursement at a later date. In *Kuhl*, on the other hand, the HMO's medical decision-making was accompanied by the actual cancellation of the medical procedure recommended, without the member/patient's knowledge or consent and without concern for the immediacy of the patient's need for that medical attention. In so acting, the HMO stripped Buddy Kuhl of the opportunity that was afforded to the plaintiff in *Corcoran* to finance the medical procedure himself. That option was

gone and, ultimately, so was Buddy Kuhl's only chance of survival.

Thus, where, as here, the HMO's medical decision-making is accompanied by deliberate acts which preclude the provision of care to a dying patient, the HMO's medical determinations can no longer be said to be merely a part of the administration of health care benefits. The *Corcoran* decision, and the previous decisions of this Court, do not preclude such a finding. Instead, these decisions confirm that the denial of payment for services is "related to" the administration of benefits. On the other hand, in light of *Corcoran's* recognition that the HMO is engaged in medical decision-making and this Court's dictate that the "relate to" language is not all-inclusive, the HMO exceeds the boundary of merely administering benefits under ERISA when it acts affirmatively to preclude the actual service to be provided to the patient/member and undertakes the medical care to be provided. Under those circumstances, the HMO's actions must no longer be protected by ERISA's preemptive force.

In the decisions below, the Eighth Circuit and District Court failed to limit the application of preemption doctrine to those matters properly "related to" the administration of benefits. The result of that error is far-reaching. The error of stretching ERISA beyond its intended reach is evident in the drastic effects of such an application upon the employees in employee benefit plans and the collateral ramifications on the American health care system. It is clear, of course, that Congress intended to create, through ERISA, a more consistent system of regulating benefit plans. Thus, if § 514(a) of ERISA is properly read to preempt the state law claims which truly "relate

to" the administration of benefits of an employee benefit plan, the goal of a uniform, federal regulatory scheme is fulfilled. If, however, § 514(a) is construed even more broadly to preempt claims which seek relief for acts which are unrelated to benefits, or to the administration of those benefits, the aim of uniformity may be obtained but only at the awesome and devastating expense of the employee and the health care to which he is rightfully entitled.

The Eighth Circuit and the District Court decisions, here, do a disservice to the authors and intended benefactors of ERISA. The decisions exaggerate the scope of ERISA's preemption doctrine to such an extent that an HMO may now make, and act upon, its own medical decisions regarding the care to be rendered to a member/patient, ignoring (without recourse) the recommendations and advice of treating physicians and specialists. Although the HMO's decision-making obviously and tangentially involves a benefit plan, the type of decision-making at issue herein does not involve the payment of benefits, but instead involves the course of medical treatment to be rendered to the member/patient. According to the Eighth Circuit and District Court, that type of decision-making is not subject to state tort law claims. Preemption, dangerously close to absolute in nature, was erroneously deemed by the Eighth Circuit and District Court to protect this type of decision-making.

B. The Purpose of ERISA is Not Furthered by the Eighth Circuit or District Court Decisions

Perhaps the most compelling reason supporting this Court's grant of Certiorari is that the result of the Eighth

Circuit and District Court decisions do not square with Congress' purpose in enacting, and the policies underlying, ERISA. The courts have instructed that "the preemption clause of ERISA must be read in context with the Act as a whole, and with Congress' goal in creating an exclusive federal enclave for the regulation of benefit plans." *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 244 (5th Cir. 1990); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 8 (1987) (Congressional purpose in enacting ERISA is "ultimate touchstone" of preemption analysis). Thus, where preemption of a state law of general application, viewed in the context of the Act as a whole, does not further Congress' purpose in creating ERISA as a federal concern, the law should not be preempted.

Congress originally enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." 29 U.S.C. § 1001; *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 103 S.Ct. 2890, 2896 (1983); *Memorial Hosp. Sys.*, 904 F.2d at 245. At the time ERISA was passed, it was stated that ERISA's

> . . . most important purpose will be to assure American workers that they may look forward, with anticipation, to a retirement with financial security and dignity, and without fear that this period of life will be lacking in the necessities to sustain them as human beings within our society.

H.R. REP. NO. 533, 93rd Cong. 1st Sess. 8, reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 4639, 4646. Senator Javits, one of ERISA's authors and leading proponents, called it "the greatest development in the life of the

American worker since social security." 120 CONG. REC. 29,933 (1974) (statement of Sen. Javits), reprinted in the LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (1976).

The Eighth Circuit held that ERISA preempted the Kuhls' state law causes of action.[4] The purported preemptive effect of the federal law, combined with the Eighth Circuit's reliance on this Court's recent decision in *Mertens v. Hewitt Assoc.*, ___ U.S. ___, 124 L.Ed.2d 161, 113 S. Ct. 2063 (1993) (holding that § 502(a)(3) of ERISA could not be construed to provide monetary remedies for a fiduciary's wrongful acts), leaves the plaintiffs with no legal redress for the wrongful death of their husband and father.[5] This result cannot be reconciled with ERISA's

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[4] The plaintiffs' claims are not ones for plan benefits, but rather tort damages. The claims do not allege improper claim processing; instead, the claims allege medical malpractice, tortious interference with a contract, and emotional distress arising from the negligent acts of medical malpractice.

[5] The preemption decision of the Eighth Circuit shields Lincoln National from liability and leaves the plaintiffs without recourse. Plaintiffs are aware that preemption normally is not dependent upon the availability of ERISA remedies. *See, Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54, 95 L.Ed.2d 39, 107 S. Ct. 1549, 1566 (1987); *but see, Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157, 162 (6th Cir. 1989), *cert. denied*, 493 U.S. 1093, 110 S. Ct. 1166, 107 L.Ed.2d 1068 (1990) (which held preemption only applies when Congress has provided an adequate remedy), *cert. denied*, 493 U.S. 1093, 110 S. Ct. 1166, 107 L.Ed.2d 1068 (1990). The plaintiffs, however, were not participants or beneficiaries as enumerated in the Supreme Court opinion or in the statute itself, and, therefore, their lack of alternate remedies in the event of preemption is deserving of consideration. *See, Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752, 755 (10th Cir. 1991).

broad remedial purpose to benefit employees and their beneficiaries, such as the plaintiffs. No conceivable federal interest, nor any purpose for which ERISA was passed, is served by allowing ERISA to act as a shield to protect professed medical professionals from tort responsibility when they interject themselves into the medical decision-making process and undertake the care of the patient/member with disastrous results. To do so turns an act passed to benefit workers on its head, and transforms it into a weapon to deprive them of rights.

Many courts and commentators have expressed concern that an overbroad application of § 1144(a) unnecessarily deprives workers of traditional rights and remedies. For example, in *Cathey v. Metropolitan Life Ins. Co.*, 805 S.W.2d 387 (Tex. 1991), the Texas Supreme Court dismissed the plaintiffs' state law misrepresentation claims as preempted by ERISA § 514(a). Justice Doggett, joined by two other justices, ruefully concurred in the dismissal, noting that through an ever-widening use of the preemption clause, "a statutory addition to workers' rights has been converted into a statutory removal of those rights." *Cathey, supra.* He continued:

> . . . the workers ERISA was intended to protect lack a remedy for wrongs unaddressed by the statute, while the companies targeted by Congress employ ERISA as an effective shield against responsibility for wrongful claims processing. . . . Under ERISA, insurers who provide group benefit plans have little incentive to deal promptly and fairly with employer participants.

Cathey, supra. See also, Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822, 827-36 (N.D. Ala. 1988) (ERISA has become

"quicksand" that will "continue to expand and preempt everything in its meandering path"); *Amos v. Blue Cross-Blue Shield of Ala.*, 681 F. Supp. 1515 (N.D. Ala. 1988) ("If the recognized purpose of ERISA was to *protect* beneficiaries, will this 'new dispensation' by judicial construction, take away all of the effective traditional remedies of the beneficiaries?") (original emphasis); Note, "Blind Faith Conquers Bad Faith" 21 Loy. L.A. Law Review 1343, 1347 (1988) (without tort liability, insurers have nothing to lose by withholding payments; preemption effectively removes incentive from insurers to deal fairly with beneficiaries); Gregory, "The Scope of ERISA Preemption of State Law: A Study of Effective Federalism," 48 U. Pitt. Law Rev. 427, 457 (1987) ("If ERISA preempted all state law relating to employee benefit plans, a dangerous vacuum would result").

The effect of ERISA's preemptive force is magnified to an even greater extent in light of the lack of other means of redress. For example, this Court's recent decision in *Mertens v. Hewitt Assocs.*, ___ U.S. ___, 124 L.Ed.2d 161, 113 S.Ct. 2-73 (1993), definitively holds that one harmed by the actions of an ERISA fiduciary is not entitled to damages, as "other equitable relief," pursuant to § 502(a) of ERISA, 29 U.S.C. § 1132(a). The Eighth Circuit Panel, almost apologetically, confirmed that the *Mertens* decision, along with the sweeping language which the courts have applied to the preemption doctrine, have created a gaping hole in the statutory remedies available to the individuals who were intended to be afforded the broadest protection under ERISA.

Pursuant to the courts' sweeping construction of the preemption doctrine, and with the advent of prospective

medical decision-making by the HMOs and the recent *Mertens* decision, ERISA has literally been converted into nothing more than an incentive for HMOs to avoid, delay or preclude the rendering of costly medical procedures to the patient/member. Without threat of legal recourse, an HMO's most cost-effective decision-making process includes the provision of only suboptimal medical care to the patient/member or the gross reality of simply allowing the patient/member to die. It no longer makes economic sense for the HMO to base its medical decision-making on the best interests of patient/members. Buddy Kuhl was a victim of that kind of dollar-driven, medical decision-making by Lincoln National, and he died as a result.

The decisions of the District and Eighth Circuit Courts, herein, provide an incentive for medical professionals, acting on behalf of HMOs, to "take over" the medical treatment of the patient/member and to simultaneously disregard the advice and recommendations of the patient/member's treating physicians and specialists. With the protective shield of ERISA, as defined by the courts below, there is nothing to protect the patient/member from the wrongful acts of the HMO health care providers. As here, the wrongful and deliberate acts of the HMO agents may very well result in the death of the patient/member but, under the Eighth Circuit's perception of the law, the patient/member or his beneficiaries have no legal recourse. It is clear that this was not Congress' intent or purpose in enacting ERISA.

c. This Court Has Authority to Protect the Goals Espoused in Creating ERISA

In its adoption, Congress clearly realized that the ERISA statute would not address every issue. With this in mind, Congress empowered federal courts with the authority "to develop a body of federal common law that govern issues in ERISA actions not covered by the act itself." *Psychiatric Institute v. Connecticut General*, 780 F. Supp. 24, 32 (D.D.C. 1992); *Kane v. Aetna Life Ins. Co.*, 893 F.2d 1283, 1285 (11th Cir.), *cert. denied*, ___ U.S. ___, 111 S.Ct. 232, 112 L.Ed.2d 192 (1990); *Foltz v. U.S. News & World Report, Inc.*, 627 F. Supp. 1143, 1176 (D.D.C. 1986). "Congress intended that the court use this authority to develop a body of federal substantive law to deal with issues involving rights and obligations under private welfare and pension plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11, 109 S.Ct. 948, 954, 103 L.Ed.2d 80 (1989).

One issue which Congress perhaps could not have predicted when drafting ERISA was the interjection of the medical utilization review process into the system. *See Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1334 (5th Cir.), *cert. denied*, ___ U.S. ___, 121 L.Ed.2d 684, 113 S.Ct. 812 (1992). The newly developing HMO practice was not one which should realistically have been addressed by Congress when drafting the ERISA statute. Today, however, with the every-expanding use of employer-sponsored HMO benefit plans, this Court must have the courage to formulate law which is necessary to properly promote the employees' interests. Relying upon the congressionally-delegated authority granted this

Court, and looking to the realities of present day HMO practices, this court can ensure the rights owed to individuals, such as Buddy Kuhl and his family, and can enforce the obligations of HMO medical personnel so that they may be held accountable for tortious acts occurring when they take actions which go beyond the mere administration of benefits and undertake the medical care of individuals, such as Buddy Kuhl.

D. There is Confusion Among the Circuit Courts on the Issue of Preemption of Emotional Distress Claims

The decisions of the Circuits are split on the issue of whether or not a claim for emotional distress is preempted by ERISA. *See, e.g., Drinkwater, infra; Johnson v. District 2 Marine Eng'rs Beneficial Ass'n,* 857 F.2d 514 (9th Cir. 1988); *Powell v. Chesapeake and Potomac Telephone Co.,* 780 F.2d 419 (4th Cir. 1985), *cert. denied,* 476 U.S. 1170 (1986). The Eighth Circuit and District Court, in rendering their decisions, erroneously chose to follow the principles of the latter two cases. Plaintiffs contend, however, that the former is more applicable to the facts herein and seek this Court's guidance in rectifying the division among this nation's Circuit Courts.

In *Drinkwater v. Metropolitan Life Insurance Company,* 846 F.2d 821, 825 (1st Cir.) *cert. denied,* 488 U.S. 909, 109 S.Ct. 261, 102 L.Ed.2d 249 (1988), the First Circuit held that a wife's claim for emotional distress was not preempted by ERISA, even though the injury was suffered as a result of a denial of benefits to her husband under an employee welfare benefit plan. In *Drinkwater,* the plan's

refusal to pay benefits was alleged to have contributed to the plaintiff's spouse's death. The *Drinkwater* court held this claim was too tangentially affected by ERISA to warrant preemption.

In the instant case, plaintiffs' claims are even more tangentially related to ERISA than the *Drinkwater* claim. Specifically, the emotional distress suffered by plaintiff Mary Kuhl herein does not flow from a denial of justified benefits under the plan, but rather arises from the cancellation of scheduled life-saving surgery by the HMO and its negligent undertaking of Buddy Kuhl's medical care, and the HMO's intentional interference in the provision of appropriate health care to Buddy Kuhl by the physicians with whom he had contracted. The plaintiff herein should clearly not suffer preemption under these circumstances, and this Court should grant the petition to resolve the conflict among the Circuits on this issue and clarify the law for the lower courts.

E. In Considering the Defendant's Motion for Summary Judgment, the Courts Below Failed to Accept as True the Evidence Averred by Plaintiffs and to View All Inferences in the Light Most Favorable to Them

This Court should grant the Kuhls' writ because the District Court and Eighth Circuit decisions are inconsistent with this Court's previous decisions regarding the appropriate standard and presumptions employed in deciding a motion for summary judgment. That is, in considering a motion for summary judgment, all inferences drawn by the court are to be viewed in the light

most favorable to the party opposing the motion. *United States v. Diebold*, 369 U.S. 654, 655 (1962). Moreover, the evidence of the party opposing the motion "is to be believed" and that party's "version of any disputed issue of fact . . . is presumed correct." *Eastman Kodak Co. v. Image Technical Services*, ___ U.S. ___, 119 L.Ed.2d 265, 277, 112 S.Ct. 2072 (1992) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986); *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 339 (1982)). *See also, Lujan v. National Wildlife Federation*, 497 U.S. 871, 888 (1990) ("where the facts specifically averred by [the non-moving party] contradict facts specifically averred by the movant, the motion must be denied").

The Eighth Circuit, in rendering its opinion in the instant case, repeated the maxim that it was to consider the facts in the light most favorable to the Kuhls. *Kuhl*, 999 F.2d at 303. However, in support of the court's primary basis for affirming the District Court's decision to grant summary judgment, the Eighth Circuit then flatly rejected the facts averred by the Kuhls, including the sworn, uncontested testimony of Buddy Kuhl's heart specialist, Dr. Bernard Levi. Dr. Levi, (a participating provider under an agreement with Lincoln National), provided an affidavit in support of the plaintiffs' Motion to Remand and in response to defendant's Motion for Summary Judgment, in which he testified:

> Notwithstanding the fact that Buddy Kuhl was my patient and notwithstanding . . . [my] . . . contractual provisions with Lincoln National, and in direct contravention of my advice to Lincoln National and to my patient,

> Buddy Kuhl, Lincoln National, in effect, canceled the surgery which had been scheduled at Barnes Hospital and sent Buddy Kuhl, against my direct recommendation, to Dr. Brodine at Research Hospital. *In so doing, Lincoln National, through its actors, assumed medical care of Buddy Kuhl.*

(emphasis added).[6]

The Kuhls also provided the District Court and Eighth Circuit Panel evidence of the manner in which Lincoln National returned Buddy Kuhl to Dr. Levi's care, after having assumed that care itself. Dr. Levi's uncontested testimony provided:

> I later learned that Dr. Brodine agreed with my recommendation and . . . Lincoln National notified me that they were following Dr. Brodine's recommendations and would authorize surgery in St. Louis as I had earlier recommended and arranged. [Lincoln National's] letter stated that Mr. Kuhl was to arrange the surgery through me. The letter also said that after the surgery "all hospital care must be rendered by Dr. Levi." Thus, *after assuming care of Buddy Kuhl and taking Buddy Kuhl from my care on June 23, 1989, Lincoln National returned Buddy Kuhl to my care on July 20, 1989.*

(emphasis added).

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[6] As indicated by Dr. Levi, the decision made by the HMO to cancel the surgery at Barnes Hospital was directly contrary to the medical advice provided by him to the agents of the HMO. Dr. Levi had informed the HMO that the alternative site for the surgery, contemplated by the HMO, was unacceptable because its surgeons were "incompetent and inadequate," and that Buddy's chances of survival, outside of Barnes, were "suboptimal" and "dismal."

Thus, the evidence submitted by the plaintiffs on this material issue of fact clearly illustrates that, despite overwhelming medical advice provided to the HMO, the doctor and nurses at Lincoln National made their own medical determination regarding the propriety of care to be provided to Buddy Kuhl, the significance of the timing of that care and the location at which the care would be rendered. The doctor and nurses at the HMO canceled the surgery at Barnes Hospital, established the appointment for Buddy Kuhl to see yet another physician (set mutually exclusive of the surgery at Barnes) and informed Buddy Kuhl that he was to proceed with their assessment of appropriate health care. In short, the HMO undertook the medical care of Buddy Kuhl.

Directly contrary to the evidence submitted by non-movant Kuhls, the Eighth Circuit found that "Lincoln National's admission that it 'canceled' the surgery cannot be stretched to imply that Lincoln National went beyond the administration of benefits and undertook to provide Buddy Kuhl with medical advice." *Kuhl*, 999 F.2d at 303. In reaching this conclusion, inconsistent with and directly contrary to the Kuhls' uncontroverted evidence (and all inferences to be drawn therefrom), the District Court and Eighth Circuit have apparently sought to promote judicial efficiency, all at the expense of justice and the express dictates of this Court. The extreme remedy of summary judgment is not appropriate, in a case such as this, where the moving party can purportedly establish its right to judgment only because the court erroneously fails to presume that the evidence of the non-moving party is true and looks, instead, upon the evidence in a manner favorable to the moving party. *See, Anderson v. Liberty Lobby,*

Inc., supra; Inland Oil & Transp. Co. v. United States, 600 F.2d 725, 727 (8th Cir.), *cert. denied*, 444 U.S. 991, 100 S.Ct. 522, 62 L.Ed.2d 420 (1979); *U.S. v. Feinstein*, 717 F. Supp. 1552, 1555 (S.D. Fla. 1989).

VIII. CONCLUSION

For the foregoing reasons, the Petitioners Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl respectfully request that their petition for a Writ of Certiorari be granted.

Respectfully submitted,

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